MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

10005 – 62 – 040306
STATE FILE NUMBER

Registration District No. **318**   Primary Registration District No. **1003**   Registrar's No. _____

(left stub column)

DO NOT WRITE ON THIS STUB   **AMENDED**

VS 300
Rev. 4/59

DATE AMENDED

1

2403035

3

4 0

5 1

6

7 0

8 1

9

10

11

12 56-0

13

54

ITEM NO. | SHOULD READ | BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

FILED OCT 2 9 1962

1. PLACE OF DEATH
   a. COUNTY
   b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: **St. Louis**   Length of stay in 1b
   c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: **Christian Hosp**   Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE **Missouri**   b. COUNTY **St. Louis**
   c. CITY OR TOWN **Moline Acres**   Inside Limits Yes ☒ No ☐
   d. STREET ADDRESS (If outside, give location) **10312 Bavon Dr.**   Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First **Henry** Middle Last **Heckenberg**
4. DATE OF DEATH Month Day Year **10. –17– 1962**

5. SEX **Male**
6. COLOR OR RACE **White**
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH **6-15-1885**
9. AGE (last birthday) **77** IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Clerk**
10b. KIND OF BUSINESS OR INDUSTRY **Retired**
11. BIRTHPLACE (City and state or country) **St. Louis, Mo**
12. CITIZEN OF WHAT COUNTRY **USA.**

13a. FATHER'S NAME **Henry Heckenberg**
13b. MOTHER'S MAIDEN NAME **Henrietta Hageman**
14. NAME OF HUSBAND OR WIFE **Mayme**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address **Harry Adam 11309 Bellefontaine Rd**

18. CAUSE OF DEATH (Enter only one cause per line)
   PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	**Broncho pneumonia**	**3 days**
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	**Ruptured Duodenal Ulcer**	**7 days**
DUE TO (c)	**Pulmonary Emphysema**	**5 yrs.**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **541.1**
PART III. If deceased was female was there a pregnancy in last 90 days ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **9-29-62** to **10/17/62** and last saw him alive on **10/17/62**
Death occurred at **10:3A** **a** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Joseph Ufen M.D.**
22b. ADDRESS **350 W. St. Anthony**
22c. DATE SIGNED **10/19/62**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal**
23b. DATE **10-19-62**
23c. NAME OF CEMETERY OR CREMATORY **Zion**
23d. LOCATION (City, town, or county) **St. Louis Co.** (State) **Mo.**

24. FUNERAL DIRECTOR **O'Sullivan Muckle Kron**
ADDRESS **8806 Jennings Rd**
25. DATE REC'D BY LOCAL REG. **OCT 19 1962**
26. REGISTRAR'S SIGNATURE **Karl Smith, M.D.**

Joel Efron
390 W. St. Anthony - Florissant
9-2 Fri.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____   Signed *Herbert J. Gan Jr.*
     Signature of Student Embalmer

Licensed Embalmer No. *4800*

P. O. Address *Kirkwood 22, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
    If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
    If this body is not embalmed, fact should be so stated above.